***Confidential Health Questionnaire***

# *Welcome to my Office*

I will do everything possible to restore your health. I offer a gentle, caring, holistic approach and can use a wide variety of modalities to reach the root of your health problems. I look forward to working with you to help you achieve optimum health." Health is not just the absence of disease...it is more...a state of well being and wellness.

Name________________________________

Address______________________________

City________________St_____Zip_______

Home Phone __________________________

Work Phone __________________________

Date of Birth________________Age ______

Male ☐ Female ☐ Height____Weight_____

Chief Complaint _______________________

Previous Treatment You've Received:

_____________________________________

Occupation___________________________

Employed By _________________________

Social Security # ______________________

Driver's License # _____________________

e-Mail Address ________________________

Referred By ___________________________

**Signature** __________________________

*I am fully responsible for all fees, services, herbs and supplements. I understand that failure to cancel a scheduled appointment within 24 hours will result in a cancellation charge for that visit.*

**Medications** Yes ☐ No ☐

| Medications/Herbs | Purpose |
|---|---|
| ______________________ | ______________ |
| ______________________ | ______________ |
| ______________________ | ______________ |
| ______________________ | ______________ |

| **Habits** | Heavy | Moderate | Light |
|---|---|---|---|
| Coffee | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ |
| Tea | ☐ | ☐ | ☐ |
| Water | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ |
| Alcohol | ☐ | ☐ | ☐ |
| Soft Drinks | ☐ | ☐ | ☐ |
| Stress | ☐ | ☐ | ☐ |

Have you ever been Hospitalized? Yes ☐ No ☐

If yes, explain ___________________________

Have you had Previous Acupuncture?

Yes ☐ No ☐

Reason ______________________________

How Long Has It Been Since You Had:

Complete Physical Exam _______________

Heart Exam __________________________

Blood Pressure Check _________________

What is your Cholesterol _______________

I am interested in hearing more about:

- ☐ Acupuncture
- ☐ Chinese Herbal Medicine
- ☐ Hormone Saliva Test
- ☐ Nutritional Analysis
- ☐ Allergy/Sensitivity Test
- ☐ Hair Analysis
- ☐ Detox Programs
- ☐ NAET (Allergy Elimination Techniques)
- ☐ Hormone Saliva Test

Other

_______________________________

Have You Had Any of The Following:

| | Yes | No |
|---|---|---|
| Alcoholism/Drug Addiction | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Appendicitis | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Chicken Pox | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Eczema | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Goiter | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Herpes | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| IBS/Crohn's | ☐ | ☐ |
| Influenza | ☐ | ☐ |
| Measles | ☐ | ☐ |
| Mental Disorders | ☐ | ☐ |
| Mumps | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ |
| Scarlet Fever | ☐ | ☐ |
| Venereal Infection | ☐ | ☐ |

Any Falls, Accidents, Injuries?

Yes ☐ No ☐

If Yes, explain ______________________

Ever Been Unconscious?

Yes ☐ No ☐

If Yes, explain ______________________

Surgery? Yes ☐ No ☐



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If Yes, kind(s) and date(s) ____________

______________________________

## SYMPTOMS

### General

| | severe | mild | none |
|---|---|---|---|
| Allergy | ☐ | ☐ | ☐ |
| Chills/Fever | ☐ | ☐ | ☐ |
| Cold Hands or Feet | ☐ | ☐ | ☐ |
| Convulsions/Epilepsy | ☐ | ☐ | ☐ |
| Dizziness | ☐ | ☐ | ☐ |
| Fainting | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ |
| Headache | ☐ | ☐ | ☐ |
| Loss of Sleep | ☐ | ☐ | ☐ |
| Loss of Weight | ☐ | ☐ | ☐ |
| Nervousness | ☐ | ☐ | ☐ |
| Nerve Pain | ☐ | ☐ | ☐ |
| Numbness/Tingling | ☐ | ☐ | ☐ |
| Unclear Thinking | ☐ | ☐ | ☐ |

**Muscle and Joint**

| | | | |
|---|---|---|---|
| Back Pain/Sciatica | ☐ | ☐ | ☐ |
| Elbow/Shoulder | ☐ | ☐ | ☐ |
| Knee/Foot | ☐ | ☐ | ☐ |
| Hernia | ☐ | ☐ | ☐ |
| Painful Tailbone | ☐ | ☐ | ☐ |
| Spinal Curvature | ☐ | ☐ | ☐ |
| Stiff Neck | ☐ | ☐ | ☐ |
| Tremors | ☐ | ☐ | ☐ |
| Swollen Joints | ☐ | ☐ | ☐ |

**Cardio-Vascular**

| | | | |
|---|---|---|---|
| Hardening of Arteries | ☐ | ☐ | ☐ |
| Blood Pressure | ☐ | ☐ | ☐ |
| Pain Over Heart | ☐ | ☐ | ☐ |
| Poor Circulation | ☐ | ☐ | ☐ |
| Irregular Heart Beat | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Swelling of Ankles | ☐ | ☐ | ☐ |

### Gastrointestinal

| | severe | mild | none |
|---|---|---|---|
| Acid Reflux | ☐ | ☐ | ☐ |
| Belching or Gas | ☐ | ☐ | ☐ |
| Colitis | ☐ | ☐ | ☐ |
| Colon Trouble | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ |
| Difficult Digestion | ☐ | ☐ | ☐ |
| Abdomen Distention | ☐ | ☐ | ☐ |
| Excessive Hunger | ☐ | ☐ | ☐ |
| Gall Bladder Trouble | ☐ | ☐ | ☐ |
| Hemorrhoids (piles) | ☐ | ☐ | ☐ |
| Worms/Parasites | ☐ | ☐ | ☐ |
| Liver Trouble | ☐ | ☐ | ☐ |
| Nausea | ☐ | ☐ | ☐ |
| Stomach Pain | ☐ | ☐ | ☐ |
| Poor Appetite | ☐ | ☐ | ☐ |
| Vomiting | ☐ | ☐ | ☐ |

**E.E.N.T.**

| | | | |
|---|---|---|---|
| Asthma | ☐ | ☐ | ☐ |
| Deafness | ☐ | ☐ | ☐ |
| Dental Decay | ☐ | ☐ | ☐ |
| Ear/Eye Trouble | ☐ | ☐ | ☐ |
| Enlarged Glands | ☐ | ☐ | ☐ |
| Enlarged Thyroid | ☐ | ☐ | ☐ |
| Failing Vision | ☐ | ☐ | ☐ |
| Far Sightedness | ☐ | ☐ | ☐ |
| Frequent Colds | ☐ | ☐ | ☐ |
| Hay Fever | ☐ | ☐ | ☐ |
| Hoarseness | ☐ | ☐ | ☐ |
| Gum Trouble | ☐ | ☐ | ☐ |
| Nose Bleeds | ☐ | ☐ | ☐ |
| Near Sightedness | ☐ | ☐ | ☐ |
| Sinus Infection | ☐ | ☐ | ☐ |
| Sore Throat | ☐ | ☐ | ☐ |

### Respiratory

| | severe | mild | none |
|---|---|---|---|
| Chronic Cough | ☐ | ☐ | ☐ |
| Difficult Breathing | ☐ | ☐ | ☐ |

### Respiratory

| | severe | mild | none |
|---|---|---|---|
| Shortness of Breath | ☐ | ☐ | ☐ |
| Spitting up Blood | ☐ | ☐ | ☐ |
| Wheezing/Phlegm | ☐ | ☐ | ☐ |

**Skin**

| | | | |
|---|---|---|---|
| Boils | ☐ | ☐ | ☐ |
| Bruises | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Eczema / Psoriasis | ☐ | ☐ | ☐ |
| Hives | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Sensitive Skin | ☐ | ☐ | ☐ |
| Varicose Veins | ☐ | ☐ | ☐ |

**Genito/Urinary**

| | | | |
|---|---|---|---|
| Bed Wetting | ☐ | ☐ | ☐ |
| Blood in Urine | ☐ | ☐ | ☐ |
| Frequent Urination | ☐ | ☐ | ☐ |
| Inability to Control Urine | ☐ | ☐ | ☐ |
| Kidney Infection/Stones | ☐ | ☐ | ☐ |
| Painful Urination | ☐ | ☐ | ☐ |
| Prostate Trouble | ☐ | ☐ | ☐ |
| Pus in Urine | ☐ | ☐ | ☐ |
| Urinary Tract Infections | ☐ | ☐ | ☐ |

**For Women Only/General**

| | | | |
|---|---|---|---|
| Ammenorrhea | ☐ | ☐ | ☐ |
| Cramps or Backache | ☐ | ☐ | ☐ |
| Excessive Flow | ☐ | ☐ | ☐ |
| Fibroids | ☐ | ☐ | ☐ |
| Hot Flashes | ☐ | ☐ | ☐ |



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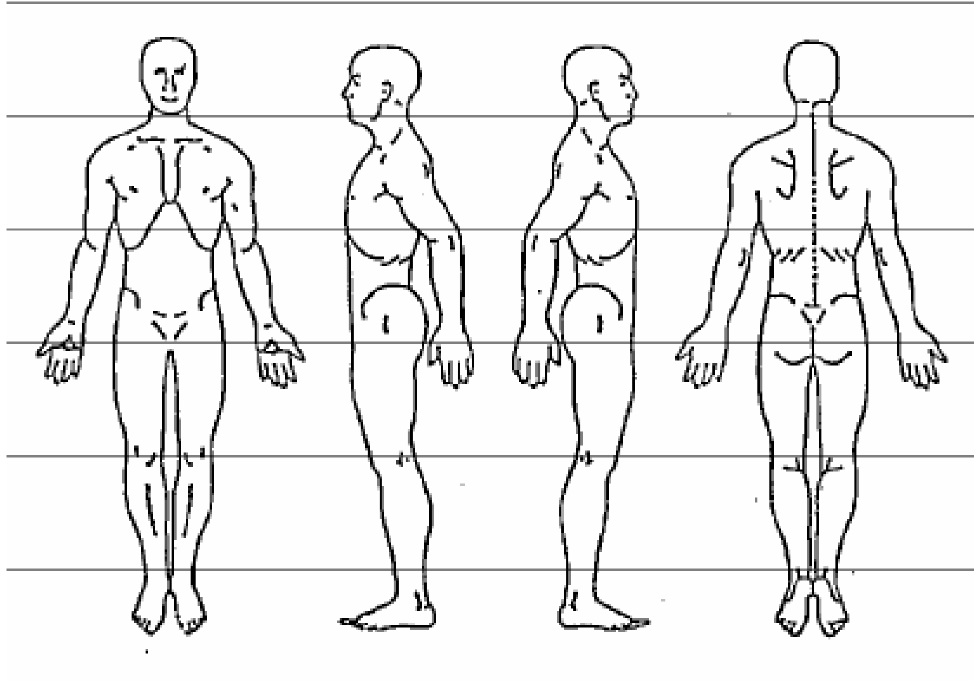
Irregular Cycle............... ☐ ........ ☐ ........ ☐
Lumps in Breast ............ ☐ ........ ☐ ........ ☐
PMS /(Peri)Menopausal ☐ ........ ☐ ........ ☐
Painful Menstruation ..... ☐ ........ ☐ ........ ☐

Vaginal Discharge ......... ☐ ........ ☐ ........ ☐

Last Period Date______/______/______
Hysterectomy______/______/______

Previous Miscarriage ... Yes ☐ No ☐

Please Circle the areas of pain/concern:



Sensations/pain: Sharp ☐ Severe ☐ Burning ☐ Shooting ☐ Moves ☐ Distending ☐ Tingling ☐ Numbness ☐ Dull ☐

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? ______________________________

What aggravates the pain? (weather, heat, cold, etc.)? ______________________________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Pain Began: _____/_____/______


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